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APPLICATION NO.	FILING DATE	FIRST NAMED INVENTOR	ATTORNEY DOCKET NO.	CONFIRMATION NO.
09/635,911	08/10/2000	Badri N. Prasad	6759	6357
25763 7590 07/30/2007 DORSEY & WHITNEY LLP INTELLECTUAL PROPERTY DEPARTMENT SUITE 1500 50 SOUTH SIXTH STREET MINNEAPOLIS, MN 55402-1498			EXAMINER KOPPIKAR, VIVEK D	
			ART UNIT 3626	PAPER NUMBER
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**Please find below and/or attached an Office communication concerning this application or proceeding.**

The time period for reply, if any, is set in the attached communication.

<b>Office Action Summary</b>	<b>Application No.</b>	<b>Applicant(s)</b>	
	09/635,911	PRASAD ET AL.	
	<b>Examiner</b>	<b>Art Unit</b>	
	Vivek D. Koppikar	3626	

-- The MAILING DATE of this communication appears on the cover sheet with the correspondence address --

#### Period for Reply

A SHORTENED STATUTORY PERIOD FOR REPLY IS SET TO EXPIRE 3 MONTH(S) OR THIRTY (30) DAYS, WHICHEVER IS LONGER, FROM THE MAILING DATE OF THIS COMMUNICATION.

- Extensions of time may be available under the provisions of 37 CFR 1.136(a). In no event, however, may a reply be timely filed after SIX (6) MONTHS from the mailing date of this communication.
- If NO period for reply is specified above, the maximum statutory period will apply and will expire SIX (6) MONTHS from the mailing date of this communication.
- Failure to reply within the set or extended period for reply will, by statute, cause the application to become ABANDONED (35 U.S.C. § 133). Any reply received by the Office later than three months after the mailing date of this communication, even if timely filed, may reduce any earned patent term adjustment. See 37 CFR 1.704(b).

#### Status

- 1) ☒ Responsive to communication(s) filed on 14 May 2007.
- 2a) ☒ This action is **FINAL**.                      2b) ☐ This action is non-final.
- 3) ☐ Since this application is in condition for allowance except for formal matters, prosecution as to the merits is closed in accordance with the practice under *Ex parte Quayle*, 1935 C.D. 11, 453 O.G. 213.

#### Disposition of Claims

- 4) ☒ Claim(s) 1-19, 21-61 and 63-68 is/are pending in the application.
- 4a) Of the above claim(s) \_\_\_\_\_ is/are withdrawn from consideration.
- 5) ☐ Claim(s) \_\_\_\_\_ is/are allowed.
- 6) ☒ Claim(s) 1-19, 21-61 and 63-68 is/are rejected.
- 7) ☐ Claim(s) \_\_\_\_\_ is/are objected to.
- 8) ☐ Claim(s) \_\_\_\_\_ are subject to restriction and/or election requirement.

#### Application Papers

- 9) ☐ The specification is objected to by the Examiner.
- 10) ☐ The drawing(s) filed on \_\_\_\_\_ is/are: a) ☐ accepted or b) ☐ objected to by the Examiner.  
Applicant may not request that any objection to the drawing(s) be held in abeyance. See 37 CFR 1.85(a).  
Replacement drawing sheet(s) including the correction is required if the drawing(s) is objected to. See 37 CFR 1.121(d).
- 11) ☐ The oath or declaration is objected to by the Examiner. Note the attached Office Action or form PTO-152.

#### Priority under 35 U.S.C. § 119

- 12) ☐ Acknowledgment is made of a claim for foreign priority under 35 U.S.C. § 119(a)-(d) or (f).
- a) ☐ All    b) ☐ Some \* c) ☐ None of:
1. ☐ Certified copies of the priority documents have been received.
2. ☐ Certified copies of the priority documents have been received in Application No. \_\_\_\_\_.
3. ☐ Copies of the certified copies of the priority documents have been received in this National Stage application from the International Bureau (PCT Rule 17.2(a)).

\* See the attached detailed Office action for a list of the certified copies not received.

#### Attachment(s)

- |  |   |
|--|---|
| 1) <input checked="" type="checkbox"/> Notice of References Cited (PTO-892)          | 4) <input type="checkbox"/> Interview Summary (PTO-413)           |
| 2) <input type="checkbox"/> Notice of Draftsperson's Patent Drawing Review (PTO-948) | Paper No(s)/Mail Date. _____                                      |
| 3) <input type="checkbox"/> Information Disclosure Statement(s) (PTO/SB/08)          | 5) <input type="checkbox"/> Notice of Informal Patent Application |
| Paper No(s)/Mail Date _____  | 6) <input type="checkbox"/> Other: _____                          |

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## **DETAILED ACTION**

### ***Status of the Application***

1. Claims 1-19, 21-61 and 63-68 have been examined in this application.

### ***Claim Rejections - 35 USC § 103***

2. The following is a quotation of 35 U.S.C. 103(a) which forms the basis for all obviousness rejections set forth in this Office action:

(a) A patent may not be obtained though the invention is not identically disclosed or described as set forth in section 102 of this title, if the differences between the subject matter sought to be patented and the prior art are such that the subject matter as a whole would have been obvious at the time the invention was made to a person having ordinary skill in the art to which said subject matter pertains. Patentability shall not be negated by the manner in which the invention was made.

3. Claims 1-5, 16-24, 27-32, 36-56, and 62-67 are rejected under 35 U.S.C. 103(a) as being unpatentable over Lash (US 2001/0020229 A1) in view of US Patent Application Publication 2002/0004725 to Martin.

(A) As per claim 1, Lash discloses an automated method for predicting the likelihood that a patient will acquire high medical service utilization characteristics, thereby becoming a high-cost patient to a managed care organization relative to other patients, within a given period of time based on a previous time period (Abstract, par. 22) comprising:

compiling a plurality, wherein the provider claims for the plurality of members occur within a base period and include a plurality of health conditions (Lash: Section [0023]);

calculating a burden of illness score for the each member based on the member's plurality of provider claims (Lash: Section [0038]);

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computing a utilization score for each health plan t-he member based on the burden of illness score and at least one explanatory variable, wherein the explanatory variable is derived from demographic data or prior healthcare utilization data associated with the member (Lash: Section [0038]);

using the utilization score to predict healthcare resource consumption in the target period by at least one plan member (Lash: Section [0006]).

As per the recitation of “each of a plurality of members in a health plan,” the Examiner respectfully submits that Lash teaches computing scores based on a period of time which is a form of Applicant’s recitation of “each of a plurality of members in a health plan” because Applicant’s invention also uses a base period of time.

Assuming *arguendo* that Lash fails to teach computer utilization scores for each of a plurality of members of a health plan, the Examiner respectfully submits that this limitation is obvious as evidenced by the teachings of Lash. As per the recitation of utilization scores being computed for “each of a plurality of members in a health plan” rather than on a filtered set of data, the courts have held that the omission of a step and its function is obvious if the function of the step is not desired. *See Ex parte Wu* , 10 USPQ 2031 (Bd. Pat. App. & Inter. 1989). *See also In re Larson*, 340 F.2d 965, 144 USPQ 347 (CCPA 1965); and *In re Kuhle*, 526 F.2d 553, 188 USPQ 7 (CCPA 1975). In this case, the elimination of the step of filtering data to only analyze a subset of data as disclosed in Lash, thus allowing analysis of “each member of a health plan,” is obvious to allow a managed care organization to accurately predict which patients will have high utilization of medical services (Lash; par. 6). As such, these changes do not present a patentable distinction over the applied prior art of record.

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Lash does not teach the following:

wherein the burden of illness score is a number calculated by identifying a number of selected disease or drug categories present in the plurality of provider claims for the member and calculating a weighted sum of the identified number of selected disease or drug categories (Note: The Office takes the position that this step is essentially a step wherein a total risk (of illness) is calculated by considering many different factors that contribute to the risk (of illness) and then multiplying each factor by a weighing factor to arrive at a intermediary value and then summing these intermediary values to arrive at a total risk (of illness) value).

However, Martin teaches this feature (Figure 3 (Items 310, 314, 318 and 322 and Section [0114])). At the time of the invention it would have been obvious for one of ordinary skill in the art to have modified the teachings of Lash with this aforementioned teaching from Martin with the motivation of having a means of arriving at a total risk value that takes both quantifies and take into account all sub-factors (segments) which contribute to a risk factor, as recited and illustrated in Martin (Figure 3 and Section [0114])).

(B) As per claims 2-4, Lash discloses using pharmacy claims, medical claims, or both (par. 24-25, 59). In one embodiment of Lash the claims can include only medical claims and the disease categories are CCG categories.

(C) As per claim 5, Lash discloses prior to the calculating step, the step of extracting a data set from the plurality of provider claims, the data set including only information from the base period, from the plurality of provider claims relevant to healthcare utilization during the target

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period, and further wherein the calculating step is based on the data set (par. 7, 24-31, 46-54, 57-59).

(D) As per claim 16, Lash discloses that many different claims variables and encounter data (e.g., an ER visit) are available for potential use in the model. the number of hospital in-patient days for respiratory-related admissions involving ICU care at any time during the admission (ICUDAY); the number of hospital in-patient days for respiratory related admissions not involving ICU care at any time during the admission (SPDAY); the number of hospital in-patient days for non-respiratory related admissions (OTHRDAY); whether the patient has had one respiratory related ER visit in the index year (ERRESPC1); whether the patient has two or more respiratory related ER visits in the index year (ERRESPC2); the number of the patient's non-respiratory related ER visits (ER\_OTHR); the number of respiratory related office visits of the patient (OV\_RESP); the number of non-respiratory related office visits (OV\_OTHR); the number of prescription drug claims (RXCNT); the presence or absence of an allergy-related diagnosis (CMALERG2); the presence or absence of a respiratory infection diagnosis (CMINFEC2); the presence or absence of another respiratory related (comorbid) diagnosis (CNIRSPIR2); the presence or absence of hypertrophied nasal turbinate diagnosis (CMNAST2); and the presence or absence of respiratory complication diagnosis (CONDLIC). Of course, other claims data and encounter information can also be stored and used in the patient database. Lash also teaches that prior to the calculating step, determining the presence of a plurality of medical episodes in the plurality of provider claims and grouping the plurality of provider claims gala into-one or more groups based on a medical episode (par. 49).

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(E) As per claim 17, Lash fails to expressly disclose Clinical Care Groups. However, Lash discloses placing the plurality of provider claims data into groups based on a medical episode (see par. 49). It is respectfully submitted that using a specific grouping (i.e. Clinical Care Groups) is another form of grouping. The skilled artisan would have it obvious to include another grouping schema within the method of Lash. The motivation being to provide a flexible grouping system when generating models thus increasing the usefulness of the models.

(F) As per claim 18 and claim 63, Lash discloses assigning the pharmacy claims to one of a plurality of groups based on a relationship to corresponding medical claim indicating the presence of the medical episode (see the number of prescription drug claims, the presence or absence of another respiratory related (comorbid disease), the presence or absence of hypertrophied nasal turbinate diagnosis (CMNAST2), and the presence or absence of respiratory complication diagnosis (CONDLIC)) (par. 49-54).

(G) As per claim 19, Lash discloses using medical claims (par. 59).

(I) As per claims 21-24 and claim 64-67, Lash discloses the weighing coefficients relating to: comorbidity (par. 49), complications (see Complic2 in Table 1), age, and sex (par. 49-54).

(J) As per claims 27-32, Lash discloses the variables pertaining to age, sex, number of chronic claims, such as respiratory claims and non-respiratory claims, the number of ER visits and office visits, the number of prescription drug claims pertaining to a respiratory disease, and the cost of medical services used by a patient in a time period (par. 10, 37, 49-54).

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(K) As per claim 38, Lash discloses using medical claims and pharmacy claims (par. 59).

Although Lash does not expressly disclose calculating a second score based on information in both the pharmacy claims and the medical claims, it is respectfully submitted that using both sets of claims would have been an obvious modification to Lash with the motivation of ensuring the accuracy of the model. (See Lash's discussion of calibrating the model to predict the true, high service use population by using "goodness-of-fit testing" to determine whether the model is good. Data from a second database is inserted into the model to determine whether it is a good fit (par. 61)).

(L) As per claims 36-37, Lash discloses using pharmacy claims and isolating patients having a score above a certain threshold, for example 90% (par. 40-42, 44, 59).

(M) As per claim 39, Lash discloses calibrating the model by comparing the score against the resource utilization for a known target year (par. 60-64).

(N) As per claims 40-42, Lash discloses using pharmacy claims, medical claims, or both (par. 24-25, 59).

(O) As per claim 43, Lash discloses calibrating the model by comparing a score against utilization for a known target period, where the utilization is for asthma related use of services (par. 60-64).



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(P) As per claims 44-46, Lash discloses using pharmacy claims, medical claims, or both (par. 24-25, 59).

(Q) As per claim 47, Lash discloses calculating multiple products using variables related to the number of hospital in-patient days for respiratory-related admissions involving ICU care at any time during the admission, the number of hospital in-patient days for respiratory related admissions not involving ICU care at any time during the admission, the number of hospital in-patient days for non-respiratory related admissions, cost of medical services, etc. (see par. 49), wherein the products are calculated by multiplying the variables by the coefficients resulting in multiple products, wherein the variable data is obtained from patient claims (It is noted that these products are considered to be a form of BOI. Applicant has not defined what a BOI is in claim 1 other than to recite that it is a number) (par. 7-10, 21-31, 37, 49-54, 57-60). These numbers are then calibrated by comparing these variables against resource utilization for a known target year (par. 60-66).

(R) As per claims 48-49, Lash discloses an automated method for predicting the likelihood that a patient will acquire high medical service utilization characteristics, thereby becoming a high-cost patient to a managed care organization relative to other patients, within a given period of time based on a previous time period (Abstract, par. 22) comprising:

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compiling a plurality, wherein the provider claims for the plurality of members occur within a base period and include a plurality of health conditions (Lash: Section [0023]);

calculating a burden of illness score for the each member based on the member's plurality of provider claims (Lash: Section [0038]);

wherein the utilization score is a weighted sum of the at least one explanatory variable and the burden of illness score (Lash: Sections [0038] and [0050]);

computing a utilization score for each health plan t-he member based on the burden of illness score and at least one explanatory variable, wherein the explanatory variable is derived from demographic data or prior healthcare utilization data associated with the member (Lash: Section [0038]);

using the utilization score to predict healthcare resource consumption in the target period by at least one plan member (Lash: Section [0006]).

As per the recitation of “each of a plurality of plan members,” the Examiner respectfully submits that Lash teaches computing scores based on a period of time which is a form of Applicant’s recitation of “each of a plurality of plan members” because Applicant’s invention also uses a base period of time.

Assuming *arguendo* that Lash fails to teach computer utilization scores for each of a plurality of members of a health plan, the Examiner respectfully submits that this limitation is obvious as evidenced by the teachings of Lash. As per the recitation of utilization scores being computed for “each of a plurality of plan members” rather than on a filtered set of data, the courts have held that the omission of a step and its function is obvious if the function of the step

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is not desired. *See Ex parte Wu*, 10 USPQ 2031 (Bd. Pat. App. & Inter. 1989). *See also In re Larson*, 340 F.2d 965, 144 USPQ 347 (CCPA 1965); and *In re Kuhle*, 526 F.2d 553, 188 USPQ 7 (CCPA 1975). In this case, the elimination of the step of filtering data to only analyze a subset of data as disclosed in Lash, thus allowing analysis of “each of a plurality of plan members,” is obvious to allow a managed care organization to accurately predict which patients will have high utilization of medical services (Lash; par. 6). As such, these changes do not present a patentable distinction over the applied prior art of record.

Lash does not teach the following:

wherein the burden of illness score is a number calculated by identifying a number of selected disease or drug categories present in the plurality of provider claims for the member and calculating a weighted sum of the identified number of selected disease or drug categories (Note: The Office takes the position that this step is essentially a step wherein a total risk (of illness) is calculated by considering many different factors that contribute to the risk (of illness) and then multiplying each factor by a weighing factor to arrive at a intermediary value and then summing these intermediary values to arrive at a total risk (of illness) value).

However, Martin teaches this feature (Figure 3 (Items 310, 314, 318 and 322 and Section [0114])). At the time of the invention it would have been obvious for one of ordinary skill in the art to have modified the teachings of Lash with this aforementioned teaching from Martin with the motivation of having a means of arriving at a total risk value that takes both quantifies and take into account all sub-factors (segments) which contribute to a risk factor, as recited and illustrated in Martin (Figure 3 and Section [0114])).

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(S) As per claim 50, Lash discloses an automated method for predicting the likelihood that a patient will acquire high medical service utilization characteristics, thereby becoming a high-cost patient to a managed care organization relative to other patients, within a given period of time based on a previous time period (Abstract, par. 22) comprising:

compiling claim data having a plurality of health conditions within a base period of time (Lash: Section [0023]);

determining the presence of a plurality of medical episodes in the claim data and grouping the claim data into one or more groups based on a medical episode (Lash: Section [0038]);

calculating a burden of illness score for each member in the health plan by identifying predefined data items within the grouped claim data (Lash: Sections[0038] and [0050]); any

computing a utilization score for each member in the health plan for the target period based upon the burden of illness score for each member and at least one explanatory variable wherein the explanatory variable is derived from demographic data or prior healthcare utilization data associated with the member (Lash: Section 0038)]; and

using the utilization score to predict healthcare resource consumption by at least one plan member (Lash: Section [0006])

As per the recitation of “the predefined data items corresponding to a plurality of health conditions and having an associated burden weight, wherein the burden of illness score for each member in the health plan is calculated by summing the predefined data items identified for each member as weighted using the associated burden weight,” Lash teaches having claims variables,

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wherein the variables include the number of hospital in-patient days for non-respiratory related admissions, the number of the patient's non-respiratory related ER visits, the number of non-respiratory related office visits, the presence or absence of hypertrophied nasal turbinate diagnosis, and presence or absence of allergies (par. 49). All of these variables are forms of "a plurality of health conditions." As per the recitation of "an associated burden weight," note the teachings of a coefficient in par. 51-53 and Table 1-2. As per the recitation of "wherein the burden of illness score for each member in the health plan is calculated by summing the predefined data items identified for each member as weighted using the associated burden weight," Lash teaches an equation which sums each variable multiplied by each coefficient. (par. 27-30).

As per the recitation of "each of a plurality of plan members," the Examiner respectfully submits that Lash teaches computing scores based on a period of time which is a form of Applicant's recitation of "each of a plurality of plan members" because Applicant's invention also uses a base period of time.

Assuming *arguendo* that Lash fails to teach computer utilization scores for each of a plurality of members of a health plan, the Examiner respectfully submits that this limitation is obvious as evidenced by the teachings of Lash. As per the recitation of utilization scores being computed for "each of a plurality of plan members" rather than on a filtered set of data, the courts have held that the omission of a step and its function is obvious if the function of the step is not desired. *See Ex parte Wu*, 10 USPQ 2031 (Bd. Pat. App. & Inter. 1989). *See also In re Larson*, 340 F.2d 965, 144 USPQ 347 (CCPA 1965); and *In re Kuhle*, 526 F.2d 553, 188 USPQ 7 (CCPA 1975). In this case, the elimination of the step of filtering data to only analyze a subset

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of data as disclosed in Lash, thus allowing analysis of “each of a plurality of plan members,” is obvious to allow a managed care organization to accurately predict which patients will have high utilization of medical services (Lash; par. 6). As such, these changes do not present a patentable distinction over the applied prior art of record.

Lash does not teach the following:

the predefined data items corresponding to a plurality of health conditions and having an associated burden weight, wherein the burden of illness score for each member in the health plan is calculated by summing the predefined data items identified for each member as weighted using the associated burden weight and wherein the utilization score is a weighted sum of the at least one explanatory variable and the burden of illness score.

However, Martin teaches this feature (Figure 3 (Items 310, 314, 318 and 322 and Section [0114])). At the time of the invention it would have been obvious for one of ordinary skill in the art to have modified the teachings of Lash with this aforementioned teaching from Martin with the motivation of having a means of arriving at a total risk value that takes both quantifies and take into account all sub-factors (segments) which contribute to a risk factor, as recited and illustrated in Martin (Figure 3 and Section [0114])).

(T) As per claim 51, Lash discloses a plurality of health conditions corresponding to a diagnosis classification or treatment classification (par. 49 and 59).

(U) As per claim 52, Lash discloses the target period being later than the base period (par. 57-59, claim 1, claim 3).

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(V) As per claim 53, Lash discloses a targeted time frame (par. 22, 24, 63, claim 3). It is respectfully submitted that this could be the same time period as the base time period.

(W) As per claim 54-56, Lash discloses using pharmacy claims, medical claims, or both (par. 24-25, 59).

1. Claims 6-15, 25-26, 57-61, and 68 are rejected under 35 U.S.C. 103(a) as being unpatentable over Lash (US 2001/0020229 A1) as applied to claim 1 and 50, and further in view of Wong et al. (5,976,082).

(A) As per claim 6, Lash does not explicitly disclose cleaning the data to remove erroneous information by comparing categories of the data set to acceptable values. Wong discloses cleaning data and performing quality checks by using threshold values to check whether an imbalance exists in the data, whether claims need to be rejected, or if multiple claims exist (col. 3 line 40 to col. 4 line 44, col. 6 lines 32-45, col. 8 lines 23-35). At the time the invention was made, it would have been obvious to include the features of Wong within the method taught by Lash with the motivation of increasing the accuracy of predictions made by a MCO to identify patients who will become or remain high-use patients, thus reducing costs for healthcare (Lash; par. 6).

(B) As per claim 7, Lash does not teach that a plurality of pharmacy codes in the plurality of provider claims are assigned to a plurality of therapeutic pharmacy classes. However, Lash does

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include analyzing pharmacy claims (par. 59). Wong discloses assigning prescribed medications including the drug codes into drug therapeutic classes (Figures 2-5, col. 7 lines 37-47, col. 11 lines 14-68). At the time the invention was made, it would have been obvious to include the features of Wong within the method taught by Lash with the motivation of utilizing a database of claims data and efficiently analyzing the claims data to quickly predict the patients who will utilize medical services (Lash; par. 6, 24).

(C) As per claim 8, Lash and Wong fails to expressly disclose using GC3 therapeutic pharmacy classes. However, Wong discloses assigning prescribed medications including the drug codes into drug therapeutic classes, specifically DM therapeutic class codes (Figures 2-5, col. 7 lines 37-47, col. 11 lines 14-68, Appendix III). It is respectfully submitted that the skilled artisan could use another form of classes other than DM class codes as disclosed by Wong. The motivation being to provide a flexible coding system when generating models thus increasing the usefulness of the models.

(D) As per claim 9, Wong discloses multiplying each of the independent variables, such as ischemic heart disease, cardiac dysrhythmias, hypertensive disease, number of co-morbid diseases, number of CHF hospitalizations, number of CHF emergency services, number of physician office visits, number of ACE inhibitor prescriptions, number of digoxin prescriptions (reads on “therapeutic pharmacy classes”), and number of loop diuretic prescriptions, by a parameter estimate and then summing the independent variables times the parameter estimates to calculate a value (reads on “burden of illness”) (col. 12 line 46 to col. 13 line 50, col. 14 line 49



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to col. 15 line 33). The motivation for combining Wong within Lash is given above in claim 7, and incorporated herein.

(E) As per claim 10, Wong discloses multiplying each of the independent variables, such as ischemic heart disease, cardiac dysrhythmias, hypertensive disease, number of co-morbid diseases, number of CHF hospitalizations, number of CHF emergency services, number of physician office visits, number of ACE inhibitor prescriptions, number of digoxin prescriptions (reads on “therapeutic pharmacy classes”), and number of loop diuretic prescriptions, by a parameter estimate and then summing the independent variables times the parameter estimates to calculate a value (reads on “burden of illness”) (col. 12 line 46 to col. 13 line 50, col. 14 line 49 to col. 15 line 33). Lash and Wong fails to expressly disclose summing a plurality of weights corresponding to relevant combinations of therapeutic pharmacy classes present for the member. However, it is respectfully submitted that when generating models typically the interactions of different variables are examined, and the skilled artisan would have found it an obvious modification to the method of Lash and Wong to include combinations of therapeutic pharmacy classes with the motivation of providing the most accurate model for the prediction of adverse health outcomes (Wong; col. 12 lines 27-31).

(F) As per claims 11 and 14, Wong discloses assigning diseases having ICD-9 codes into a plurality of sub classes (col. 9 line 45 to col. 10 line 31) and summing the independent variables or values for the sub classes multiplied by the parameter estimates to calculate a value (reads on “burden of illness”) (col. 12 line 46 to col. 13 line 50, col. 14 line 49 to col. 15 line 33).

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(G) As per claims 12-13 and 58-59, Wong discloses using ICD-9 codes and therapeutic classes to assign diseases into appropriate subclasses (col. 6 lines 17-32, col. 9 lines 43-63). Wong discloses assigning prescribed medications including the drug codes into drug therapeutic classes, specifically DM therapeutic class codes (Figures 2-5, col. 7 lines 37-47, col. 11 lines 14-68, Appendix III). Although Wong fails to expressly recite CCG or CCG classes or categories, it is respectfully submitted that the skilled artisan could use another form of classes other than ICD-9 class codes as disclosed by Wong. The motivation being to provide a flexible coding system when generating models thus increasing the usefulness of the models.

(H) As per claim 15 and claim 68, Wong discloses the parameter estimates including the total costs, in-patient hospital costs, emergency room costs, doctor costs, cardiovascular costs, and CHF costs, wherein the costs are associated with an ICD-9 code (col. 12 line 46 to col. 13 line 50, col. 14 line 49 to col. 15 line 33).

(I) As per claims 25-26 and 61, Lash discloses using data pertaining to the cost of medical services for each patient in the previous time period (par. 37). However, Lash does not include the predetermined weight factor is calculated based on an average incremental cost associated with a group or with a group for a benchmark population. Wong discloses a parameter estimate relating to the cost of in-patient hospital costs, emergency room costs, doctor costs, and pharmacy costs (col. 12 line 46 to col. 13 line 50, col. 14 line 49 to col. 15 line 33). At the time the invention was made, it would have been obvious to one of ordinary skill in the art to include

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the features of Wong within the method of Lash with the motivation of accurately predicting which patients will be the greatest utilizers of medical resources (Lash; par. 5-6).

(J) As per claim 57, Lash does not explicitly disclose cleaning the data to remove erroneous information by comparing categories of the data set to acceptable values. Wong discloses cleaning data and performing quality checks by using threshold values to check whether an imbalance exists in the data, whether claims need to be rejected, or if multiple claims exist (col. 3 line 40 to col. 4 line 44, col. 6 lines 32-45, col. 8 lines 23-35). At the time the invention was made, it would have been obvious to include the features of Wong within the method taught by Lash with the motivation of increasing the accuracy of predictions made by a MCO to identify patients who will become or remain high-use patients, thus reducing costs for healthcare (Lash; par. 6).

(K) As per claim 60, Wong discloses CPT and ICD-9 codes corresponding to health conditions (col. 6 lines 17-31, col. 8 lines 45-60, col. 9 line 46 to col. 10 line 65).

2. Claims 33-34 is rejected under 35 U.S.C. 103(a) as being unpatentable over Lash (US 2001/0020229) as applied to claim 1, and further in view of Lockwood (5,706,441).

(A) As per claims 33-34, the teachings of Lash in the rejections above are incorporated herein.

Lash discloses calculating a probability that a patient will be a high use patient of medical resources in the following year, wherein the score/probability is scaled to run from 0 to

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100, with the higher number meaning a greater probability that the patient will become high-cost (par. 41, 49-56). Lash does not expressly disclose the step of dividing the score by an average score for the group or by an average score for a benchmark group.

Lockwood discloses comparing the severity scores for sickness episodes against benchmarks by dividing the scores with the benchmarks and comparing a score by the average score for a group (col. 11 line 44 to col. 13 line 41). At the time the invention was made, it would have been obvious to one of ordinary skill in the art to combine the teachings of Lockwood within the method of Lash with the motivation of identifying and assessing high risk patients (par. 41, 49-56).

### ***Response to Arguments***

1. Applicant's arguments filed on May 14, 2007 have been fully considered but they are not persuasive. Applicants arguments will be addressed in sequential order as they were addressed in the "Remarks" section on May 14, 2007.

(1) Applicants argue that Lash does not teach computing a utilization score for each health plan the member based on the burden of illness score and at least one explanatory variable, wherein the explanatory variable is derived from demographic data or prior healthcare utilization data associated with the member. However, the Office would like to note that Lash does in fact teach this very feature (Lash: Sections [0038] and [0050]).

(2) Applicants argue that Lash does not calculating a burden of illness score for each member based on the member's plurality of provider claims, wherein the burden of illness score is a number calculated by identifying a number of selected disease or drug categories present in the

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plurality of provider claims for the member and calculating a weighted sum of the identified number of selected disease or drug categories. However, this argument is now moot in view of the newly added Martin reference which does teach this feature, as noted above.

(3) Applicants argue the following: Lash does not teach or suggest computing a utilization score using both the burden of illness score and at least one explanatory variable that is either demographic data or prior healthcare utilization data for each health plan member. Lash does not teach, suggest, or enable one to calculate a utilization score for each member in a non-homogeneous group of health plan members, i.e., having a plurality of health conditions, disease categories or drug categories. Nor does Lash teach the calculation of the burden of illness score that is required prior to calculating the utilization score for each member. However, this argument is now moot in view of the newly added Martin reference which does teach this feature, as noted above.

### ***Conclusion***

1. **THIS ACTION IS MADE FINAL.** Applicant is reminded of the extension of time policy as set forth in 37 CFR 1.136(a).

A shortened statutory period for reply to this final action is set to expire **THREE MONTHS** from the mailing date of this action. In the event a first reply is filed within **TWO MONTHS** of the mailing date of this final action and the advisory action is not mailed until after the end of the **THREE-MONTH** shortened statutory period, then the shortened statutory period will expire on the date the advisory action is mailed, and any extension fee pursuant to 37 CFR 1.136(a) will be calculated from the mailing date of the advisory action. In no event,

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however, will the statutory period for reply expire later than SIX MONTHS from the mailing date of this final action.

2. Any inquire concerning this communication or earlier communications from the examiner should be directed to Vivek Koppikar, whose telephone number is (571) 272-5109. The examiner can normally be reached from Monday to Friday between 8 AM and 4:30 PM.


If any attempt to reach the examiner by telephone is unsuccessful, the examiner's supervisor, Joseph Thomas, can be reached at (571) 272-6776. The fax telephone numbers for this group are either (571) 273-8300 or (703) 872-9326 (for official communications including After Final communications labeled "Box AF").

Another resource that is available to applicants is the Patent Application Information Retrieval (PAIR). Information regarding the status of an application can be obtained from the (PAIR) system. Status information for published applications may be obtained from either Private PAIR or Public PAX. Status information for unpublished applications is available through Private PAIR only. For more information about the PAIR system, see <http://pair-direct.uspto.gov>. Should you have questions on access to the Private PAIR system, please feel free to contact the Electronic Business Center (EBC) at 866-217-9197 (toll-free).

Sincerely,

  
Vivek Koppikar

7/20/2007

  
C. LUKE GILLIGAN  
PRIMARY EXAMINER  
TECHNOLOGY CENTER 3600